



11510 OLD GEORGETOWN ROAD, SUITE E
NORTH BETHESDA, MARYLAND 20852
301-493-4496 FAX: 301-493-4165

PATIENT HISTORY FORM

PERSONAL HISTORY

Patient's Name	Birthdate	Sex ☐ Male ☐ Female
Street Address		
City / State / Zip	Email Address	
Home Phone	Work Phone	Cell Phone
Employer	Occupation	Emergency Contact
Emergency Contact	Name of General Dentist	
Preferred Pharmacy Name	Phone Number	Address

INSURANCE INFORMATION

Dental insurance? ☐ Yes ☐ No	Subscriber Name	Relationship ☐ Self ☐ Spouse ☐ Parent
Insurance Company	Member ID/SSN	Subscriber's Birthdate
Secondary dental insurance? ☐ Yes ☐ No	Subscriber Name	Relationship ☐ Self ☐ Spouse ☐ Parent
Secondary Insurance Name	Member ID/SSN	Subscriber's Birthdate

MEDICAL HISTORY

Name of Your Physician	Require pre-medication/antibiotic before dental treatment? ☐ Yes ☐ No	If yes, reason
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Medications you are taking

Do you have, or have you had, any of the following? Please answer Yes or No for each medical ailment.

☐ Y ☐ N Heart Disease	☐ Y ☐ N Blood Disorder	☐ Y ☐ N Ulcer/Colitis
☐ Y ☐ N Heart Murmur	☐ Y ☐ N Malignancy/Cancer	☐ Y ☐ N Sinus Trouble
☐ Y ☐ N Mitral Valve Prolapse	☐ Y ☐ N Radiation/Chemotherapy	☐ Y ☐ N Organ Transplant
☐ Y ☐ N Pacemaker/Artificial Valve	☐ Y ☐ N Lung Disease/TB	☐ Y ☐ N Allergies (list below)
☐ Y ☐ N High Blood Pressure	☐ Y ☐ N Thyroid Condition	☐ Y ☐ N Pregnant?
☐ Y ☐ N Stroke	☐ Y ☐ N Liver Disease	☐ Y ☐ N Birth control pills?
☐ Y ☐ N Shortness of Breath	☐ Y ☐ N Diabetes	☐ Y ☐ N Bisphosphonates?
☐ Y ☐ N Swelling of Feet/Ankles	☐ Y ☐ N Epilepsy/Neurological	☐ Y ☐ N Hepatitis A/B/C
☐ Y ☐ N Fainting/Dizziness	☐ Y ☐ N Glaucoma	☐ Y ☐ N AIDS/HIV Positive

Allergies to any medication or Latex? (Penicillin, Novocaine, Codeine, etc.)

DENTAL HISTORY

Do you feel discomfort when your tooth comes in contact with:

Hot foods or liquids (soup, coffee, etc.)	☐ Yes	☐ No
Cold foods or liquids (ice cream, cold water, etc.)	☐ Yes	☐ No
Sweet or sour foods (candy, oranges, fruit, etc.)	☐ Yes	☐ No
When you bite down or chew?	☐ Yes	☐ No

Do any of the above symptoms linger for more than a minute or so?

Comments

Have you ever undergone endodontic treatments? ☐ Yes ☐ No

Print Name _____ (person signing)

Relationship if other than patient _____

Signature _____

Date _____

All signatures must be by a parent or guardian if the patient is under 18 years old.



Informed Consent for Endodontic Treatment

Patient Name (please print): _____

CONSENT AND TREATMENT UNDERSTANDING

We will make every effort to advise you as to the expected number of appointments necessary, the time needed for each appointment, what you may expect from treatment, and the estimated fee. It is understood that endodontic treatment is a procedure intended to retain a tooth that may otherwise require extraction. Although endodontic treatment has a high degree of clinical success, **it is a biological procedure and cannot be guaranteed**. Occasionally, a tooth that has had endodontic treatment may require retreatment, surgery, or extraction.

Complications of root canal therapy and/or anesthesia may include swelling, discomfort, infection, bleeding, trismus (limited jaw opening), changes in occlusion (biting), jaw muscle and joint cramps or spasms, involvement of the sinuses, and numbness or tingling of the lip, gum, or tongue, which rarely is protracted and even more rarely is permanent. During treatment, complications may be discovered that make treatment impossible or require dental surgery. These complications may include blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, gum disease, and fractures of the teeth. During treatment, fracture of a crown or porcelain may occur.

When your treatment is completed, your tooth will need a final restoration, such as a filling, cap, or crown. Our fee does not include this service. Your referring dentist will render this service, which is equally important for the preservation of your tooth.

PAYMENT AND DENTAL INSURANCE

Payment: It is expected that payment for all treatment be made in full at the time treatment is completed. We gladly accept cash, check, Visa, Discover, or MasterCard. A 2% surcharge will be applied to all credit card payments. This surcharge is not applied to debit card payments, checks, cash, or other non-credit-card payment methods.

Dental Insurance: As a convenience to you, our office will complete the necessary forms and submit them to your insurance company. However, each patient remains responsible for the entire account. As most insurance companies provide coverage from 50% to 80%, we require a minimum of 30% of the fee prior to completion of your treatment. If your insurance payment is more or less than expected, your account will be adjusted accordingly. All accounts more than 60 days overdue will be assessed a finance charge of 15% A.P.R. The signature below verifies patient receipt of the Notice of Privacy Practices.

If you have any questions regarding your treatment or fees, we will be happy to discuss them with you. Should you have any concerns between visits or after completion of your treatment, please do not hesitate to call.

I have read and understand the above information and consent to endodontic evaluation and/or treatment as recommended by the endodontist.

Print Name _____ (person signing) Relationship if other than patient _____
Signature _____ Date _____